MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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9:30 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Assessing payment adequacy and updating Medicare payments
-- Skilled nursing facility services 2
-- Susanne Seagrave, Sally Kaplan

-- Home health services 18
-- Sharon Cheng

DR. SEAGRAVE: Thank you. Good morning.

Today I will briefly review some of the market factor and other evidence that you have already seen regarding the context of MedPAC's payment adequacy framework. I will also highlight some new preliminary information on quality of care in SNFs since the SNF PPS, discuss some concerns that have been expressed with Medicare margins for SNFs and request feedback from the commission on the draft recommendations. The final versions of these recommendations will go into MedPAC's March, 2003 report to the Congress.

First, I want to just briefly remind the commission of the role that skilled nursing facilities play in the Medicare program. Since you've seen most of this, I'll just highlight a few points.

SNFs serve about 1.4 million beneficiaries per year, representing about 3.5 percent of all beneficiaries. Prior to the implementation of the SNF prospective payment system, Medicare's SNF spending grew rapidly. In 2001, Medicare SNF spending totaled about $15.3 billion or about 6.5 percent of total Medicare spending.

I also want to point out that in 2001 about 10 percent of nursing home residents and about 56 percent of patients in hospital-based SNFs were paid for by Medicare. These represented about 10 percent of nursing home revenues and 2 percent of hospital revenues.

CBO projects the total Medicare payments to SNFs will grow an average of about 8 percent over the next five years, although CBO has indicated that this number may be revised downward in its new baseline projections due out sometime between the end of January and March.

Each year MedPAC goes through a multi-step process in arriving at our update recommendations. We start by assessing current payment adequacy, which means we examine current market factors, evaluate the appropriateness of current costs, and estimate the relationship between current Medicare payments and SNFs costs for fiscal year 2003.

Next, we examine evidence of anticipated changes in SNF costs for fiscal year 2004. Based on this information, we determine appropriate payment update recommendations for fiscal year 2004.

Now, I will just briefly review some of this market factor evidence that you've already seen at the previous two meetings. With regard to entry and exit of providers we find that the total number of SNF facilities has remained relatively stable between 1998 and 2002, with the number for freestanding facilities increasing by about 3 percent and the number of hospital-based facilities decreasing by about 26 percent.

The volume of SNF services provided to Medicare beneficiaries generally increased in 2000, the most recently available data, due in large part to an increase of approximately one day in the average length of stay. Although the total number of discharges remained relatively stable, the number of the Medicare covered days in SNFs increased by about 4 percent.

The available evidence also indicates that Medicare beneficiaries needing rehabilitation therapies generally had no delays in accessing SNF services. However, patients with expensive non-rehabilitation therapy needs may stay in the acute care hospital setting longer. It is unclear whether remaining in the acute care hospital longer is an inappropriate outcome for these patients.

Finally, our review of the evidence indicates that hospital-based SNFs have access to capital through their parent hospital organizations and this depends, of course, on the financial status of the hospital. And freestanding SNFs' access to capital may have diminished somewhat because of recent bankruptcies, payment uncertainties, and the high cost of liability and insurance. However, this may be outweighed by low demand for new capital to finance construction in the near term, resulting from large capital investments prior to the PPS.

Overall, the evidence suggests that the market factor evidence suggests that Medicare payments to SNFs are at least adequate to cover the cost of providing SNF services to Medicare beneficiaries.

Next, we evaluate the appropriateness of current SNF costs and find that prior to the SNF PPS reported SNF costs were believed to have been excessively high. There are a number of reasons for this which we've discussed previously. Under the SNF PPS, however, SNFs have strong incentives to reduce the costs of caring for SNF patients and SNFs have responded to these incentives accordingly by negotiating lower prices for contract therapy and pharmaceuticals, by substituting lower costs for higher cost labor, by decreasing the number of therapy staff they employ and by decreasing the number of minutes per week of therapy they provide.

However, this raises the question of whether quality of care, what's been happening to quality of care since the PPS with these decreases in costs. We reviewed the evidence and can find no evidence of decreases in the quality of care over this time.

Preliminary information from a national study of SNF patients indicates no changes in several quality indicators

including activities of daily living scores, walking scores, re-hospitalization rates, and incidents of mortality.

Similarly, preliminary evidence from a study of approximately 84,000 beneficiaries in SNFs in Ohio finds no change in most of the quality indicators examined since the SNF PPS. However, the study does find statistically significant improvements in re-hospitalization rates among certain facilities between 1997 and 2000 and improvements in walking scores from 1999 to 2000. This was not found to be the results of SNFs accepting healthier patients on average.

We also examined evidence of changes in nursing staff ratios. As you know, studies show that increased nursing staff time in nursing facilities is generally associated with improved quality of care. Recent evidence suggests that nursing staff time has increased by between two and five minutes per patient day since implementation of the SNF PPS and that the mix of staff time has shifted from more to less skilled. Although the first finding likely indicates that quality of care in SNFs is at least not decreasing, we did not yet know what the latter finding might mean for quality of care.

Finally, SNFs have additional incentives to improve quality regardless of cost pressures because CMS has recently begun to publish nationwide reports that include individual nursing facility scores on certain quality indicators. CMS is also devoting resources to help nursing facilities improve their scores on these indicators.

We therefore can find no evidence of reductions in the quality of care, even as we find abundant evidence that costs have decreased in SNFS since the SNF PPS. Together, this information suggests that productivity in this sector has improved.

Finally, in assessing the adequacy of SNF payments we estimate the relationship between Medicare payments and Medicare costs for SNF services in fiscal year 2003 and find that the average Medicare margins across all SNFs are about 5 percent, with the average for freestanding SNFs -- I remind you that those are 90 percent of all SNFs -- around 11 percent and the average for hospital-based SNFs around negative 36 percent. We can find almost no efforts in Medicare margins by urban or rural location.

It is worth noting that we used a conservative methodology for estimating the SNF Medicare margins this year. Had we not taken this approach, the margins we estimate would have been higher than the ones shown.

From this evidence we conclude that overall Medicare payments to SNFs are more than adequate to cover SNFs' costs of caring for Medicare patients. However, we remain concerned about the distribution of monies within the system.

Now, I want to turn to addressing a few concerns that have been raised about the SNF Medicare margins. One issue that has been brought to our attention is whether or not it is appropriate to present margins by types of providers, such as hospital-based

or freestanding or part of a top 10 chain or not part of a top 10 chain. Some people suggest that underlying characteristics of SNFs such as their occupancy rates, location, Medicare volume or percentage of Medicaid days do a better job of explaining SNFs' financial performance. We discuss Medicare margins by provider type, hospital-based and freestanding, and by location, urban and role, because many of the commissioners and other interested parties find this information useful in thinking about the state of the industry.

However, at least in the short run we propose recommending adjustments to the system so that Medicare payments better track the expected resource needs of patients instead of recommending differential updates by facility type.

Another issue that has been raised is the SNF marketbasket forecast error. The forecasted SNF marketbasket, which is used to update payment to SNFs each year, has underestimated the actual SNF marketbasket for the last few years since the SNF PPS. MedPAC discussed this issue with the actuaries who compute the SNF marketbasket. They indicated that the forecast error has caused SNF payments to be about 3 percent lower than they otherwise would have been had the forecast error been corrected.

However, MedPAC's payment adequate framework implicitly takes this into account in determining whether current payments are at least adequate compared with current costs. Had the forecast error not been corrected, this would have raised Medicare margins above the ones that we report here but it would not changed our assessment of current payment adequacy.

Also, if CRS were to correct for the marketbasket forecast errors that underestimate the actual marketbasket, they would also need to correct for forecast errors that overestimate the actual marketbasket. It is assumed that the two types of forecast errors balance each other out over time.

A final issue with the SNF marketbasket is the lack of a cost weight for professional liability insurance. We also spoke with the actuaries about this issue and they told us that they did not have the data necessary to include this component in the SNF marketbasket but that the weight for this component is captured in the marketbasket index, just not as a separately identifiable component.

In addition, they indicated that the Medicare cost reports would be the most reliable source of information for this but that few SNFs fill out this section of the cost report currently.

Finally, some have expressed concerns about rising labor costs in the SNF industry due to the nursing shortage. Rising labor costs are accounted for in the SNF marketbasket which MedPAC uses to increase costs each year in projecting Medicare margins. To the extent that nursing facilities are switching from using higher cost labor to lower cost labor this would tend to offset some of a cost increases.

Finally, in our payment adequacy framework, I wanted to

discuss the anticipated cost changes for 2004. First, we look for major quality enhancing new technologies that will be expected to significantly raise costs over the course of the next year and can find no evidence of this type of technology in the SNF sector. In predicting cost growth over the next year, we also look for evidence of cost lowering, increases in productivity, or changes in the product. As mentioned before, we find abundant evidence that SNFs costs of caring for Medicare beneficiaries have been decreasing since the SNF PPS. At the same time, however, we can find no evidence of decreases in the quality of care. We expect these trends to continue in the coming year.

Just one last step before I present the draft recommendations that you saw at the December meeting. I would like to remind the commission that last year we handled the SNF payment updates differently by recommending differential updates to freestanding and hospital-based SNFs. We did this because we believed that the development and implementation of a new SNF patient classification system would take too much time. We recommended differential updates in the meantime.

This year we want to recommend more immediate measures to balance the distribution of payments in the system so they better track the expected resource needs of SNF patients and we feel that differential updates are no longer necessary as a short-run pressure.

Thus, because we estimate that overall Medicare payments to SNFs are more than adequate to cover the cost of Medicare beneficiaries, staff propose recommending that the Congress eliminate the update to payment rates for skilled nursing facility services for 2004. The update in current law is marketbasket minus .5 with the SNF marketbasket currently projected at 2.9 percent for fiscal year 2004. This, of course, is always subject to change.

Within the budget categories that MedPAC has developed, a zero update for SNFs would decrease Medicare spending relative to current law in the category of between $200 million and $600 million for 2004 and between $1 billion and $5 billion over five years.

Should I go through all the recommendations?

However, as mentioned before, we feel it is critical to balance the distribution of resources in the system to better track the expected resource needs of SNF patients, especially since we have evidence that hospital-based SNFs treat a higher proportion of these types of patients.

Thus, staff proposes that we continue recommending, as in previous years, that the secretary develop a new classification system for SNFs. However, because this may take time to accomplish, staff propose recommending that the secretary draw on new and existing research to reallocate payments to achieve a better balance of resources between the rehabilitation and non-rehabilitation groups.

Further, we suggest recommending a more immediate fix to the distribution of money in the payment system. We propose recommending that the Congress immediately give the secretary the authority to remove some or all of the 6.7 percent payment add-on currently applied to the 14 rehabilitation RUG-III payment groups and as appropriate to reallocate money to do non-rehabilitation RUG-III groups to achieve a better balance of resources among all of the groups. We expect this reallocation of resources to be spending neutral.

Finally, we recommend that the secretary continue an excellent series of studies on access to skilled nursing facility services. This recommendation would not have an impact on Medicare benefit spending.

Thank you. This concludes my presentation.

MR. DeBUSK: On the new classification system, where are we at on that? Does anyone have any idea how far that's progressed or is it stalemated, or what?

DR. SEAGRAVE: The indication in the Federal Register last year was that CMS thought that it might be close to suggesting a refinement to the classification system but they pulled back because they needed to look at the implications further. No one is clear on when they might propose such a refinement.

They're supposed to provide information on alternatives on January 1st, 2005.

MR. MULLER: While it's early to see the consequences of the change in the nursing mix, there is some evidence in hospitals when they started changing the nursing mix roughly about 10 years ago that, in fact, it did have an effect on quality of care. There are recent articles in JAMA and the New England Journal on that. So I think it's something we should be tracking.

Again, I think also the amount of nursing care inside hospitals is greater than the amount in nursing homes, just on an hourly basis per day. But I would suspect as the evidence unfolds over the course of several years -- and it took about four or five years for that to unfold in the hospital setting -- that we might see some effects on the quality of care. Again, I agree with you, it was difficult to tell at the beginning of the hospital experiment but there is evidence that it did occur.

MS. BURKE: I was going to raise the same point Ralph raised. I am quite concerned that there is an indication that there may be a shift, and in fact there is evidence that that shift has, in the past, made an impact in terms of quality. So tracking that, in terms of the nursing mix, I think is quite important.

I also wanted to clarify what I believe I understood, but wanted to state it explicitly, and that is that the 20 percent add-on that was provided for and maintained in BIPA, with respect to the non-rehab RUGS, remains in place. It is not our intention to alter that; correct?

DR. SEAGRAVE: That is correct; yes.

DR. WOLTER: Just a couple comments. First of all, I

thought it was a strong chapter and I think the recommendation to reallocate the 6.7 percent payments that went to the rehab RUGS makes good sense given the other information we have. It's hard to know how that would play itself out however and how soon it would play itself out. And with the information that hospital-based SNFs are taking higher acuity patients and more complex patients with the rather high exit rates over the last few years of hospital-based SNFs, I am really worried about the potential that the care of these types of patients could be impaired in the short to medium term if this doesn't play itself out the way we'd like it to. I wonder if our recommendation would be stronger if we did include recommending an update for hospital-based SNFs if it takes a while to sort through how the 6.7 percent reallocation would occur.

I am very worried about the negative margins, the high exit rates, and this particular group of patients.

MR. HACKBARTH: Reactions to Nick's proposal?

DR. NEWHOUSE: One thing to put the exit rates in perspective is the very high entry rates in the '90s. In effect, we're somewhat unwinding history. But I don't think we've gotten all the way back to where we were.

MS. BURKE: But Joe, as I recall in the '90s, the entry rate was largely on the freestanding side rather than the hospital-based side.

DR. NEWHOUSE: That was not my recollection.

MS. BURKE: My recollection is it may not been dramatic but I think that -- at least my collection is that there were more on the freestanding side. I may be wrong. That's actually worth looking at, but I also would agree with what Nick had said. I think there is this issue if, in fact, the Congress fails to respond to the recommendation and doesn't give the authority, there will be an issue in terms of the hospital-base that I think there's some consideration what the alternative might be.

MR. SMITH: I share Nick's concern and there ought to be a way to restructure this recommendation to make that point explicit.

I also thought, it's a picky language question, but that we ought to remove as appropriate. Our intent here is to argue that money ought to be shifted from the rehabilitation RUG-III groups to the non-rehab groups. So the as appropriate suggests that it might not be appropriate. Clearly we think it is appropriate and we ought to be explicit about that.

MR. MULLER: Also to Nick's point, and I agree with it, is I think implicit in our recommendation here is that the negative margin of the hospital-based SNFs would be covered from elsewhere and part of the elsewhere -- since the higher positive margins is in the inpatient program. And I think over the course of the day we'll have probably a series of recommendations of where that higher inpatient margin is used to cover other things where they are negative. We should probably start toting up in our recommendations how many times that higher inpatient margin gets

used to support other things. Because I think with the negative 20 or 30 percent, I don't have it memorized right there, on this, even for those hospitals that have considerable inpatients SNF units, that could be a considerable drain of their margins from elsewhere to cover that.

MR. DURENBERGER: Mr. chairman, I have a slightly different point I'd like to make on the initial recommendation. My personal preference, and as you all know I'm just three or four meetings into being on the commission.

My personal preference is that we recommend a marketbasket increase less productivity and I just went to tell you why my instincts are that way. I think it's a well-done paper and we've been through this before and I understand the background and the research.

I'm challenged not so much by skilled nursing facility margins as I am by the adequacy of the way in which both Medicare and Medicaid programs provide adequate services for people who are, in many cases, somewhere near the end of life, in practically all cases dependent on others, in many cases suffering from one or more chronic illnesses, and for certain periods of time and for certain conditions they are hospitalized and/or placed in a different care setting or regimen within a skilled nursing facility.

So if I may to my colleagues make three points. One is the nature of the people served by the Medicare program are the kind of people that, from my standpoint, I would like to see cared for in a skilled nursing facility rather than in a hospital if that's at all possible. And to the extent that there's time they have to spend in the hospital I'd like to see them in and I'd like to see them out.

And it's because the nature of the care that they actually need, the nature of the dependence on family to help them in that care, and the particular kind of staff is in the skilled nursing facility, it's not in the hospital. Because it's a broader kind of dependence and a multiple set of needs that experience tells us is better cared for in skilled nursing facilities. So my bias is towards the skilled nursing facility, the freestanding, whenever we want to call it.

Which gets me to the second point, and I raised this last time and it's sort of like the issue of subsidies. I don't think it's good policy to have institutional cross subsidies or provider cross subsidies. But I do think when you have two public programs that are like Medicare and Medicaid programs, and you have right now I guess some 6 million people who are called dual eligibles who are falling between both of these programs that there's nothing wrong with cross subsidization between programs. And I don't know, maybe that's not our place to think about it, but I do think about it because, for a variety of reasons, I am looking at this issue not as are skilled nursing facility making 5 percent, 4 percent, 7 percent, 11 percent. But where is the best care being provided for these kinds of people.

I think we know about the dual eligibles. They're a relatively small percentage, in the teens I think, of both the Medicare and Medicaid program but they're consuming like 30 to 35 percent of the program money in each case. So it says to me that spending that money wisely, appropriately, is critically important.

For that reason is my instinct to prefer a relatively small increase, I guess, to no increase at all because the line is obviously coming down.

The thing, and this is what concerned me before and I mentioned this a month ago, and it is the use of the NIC report to in effect imply -- well, it doesn't imply, it says demand for capital is low. Another quote is no problem with access to capital. The implication, being that there's really nothing wrong out there on the skilled nursing facility side and, as a matter of fact quite the contrary is true, and it's particularly true of the non-profits, I think, many of which are very small. They're run by religious orders or whether the case may be across this country.

So I called Bob Kramer who runs NIC. And I said this is the way this report is being used at MedPAC. And he said number one, the one the database is relatively old for this report. It goes back to '98-'99 when PPS was first being phased in.

He said that in that same report they indicate that net operating margins across the board are probably stable or better for about half of the nursing facilities but they're below average for another half. And this is in the 2001 report.

And then he went on to point out to me that there were five or six factors or circumstances that were not accounted for in that report. One is what's happened to liability insurance premiums, and he used this figure not I, have gone from an average of $30 a bed to $3,000 a bed, the state fiscal crises that we all know about, the utility rate increases, the labor costs, the GAO and CMS reports about the pressure to increase hours of care per resident, that sort of thing that's going on.

And then the issue of the aging of the nursing home stock which is also a reality. That many of these nursing homes that we're talking about today are old. They were built in the '60s and the '70s in response to the payment signals that people were getting at that particular point in time.

And at least from the state level people are saying they would like to change the nature of those facilities but they can't afford to do it because of the income stream.

So it's my elaboration on a point I tried to make last time and because of the fact that we're really on behalf of all of these -- many of these people with two different programs, I'm left very uncomfortable simply saying I can look at this only as Medicare. I have no information about the Medicaid side in this report, as it relates to some of these facilities.

And so my preference is that we consider something other that a zero increase.

MR. HACKBARTH: I would just like to, for a second, pick up on the Medicaid point. Dave and I have discussed this a bit, so I know you know what I'm about to say but I just want to share it with the larger audience.

I basically have three concerns about using Medicare dollars to offset Medicaid losses. One is that the Medicare patients represent on average a small percentage of the total patient volume, about roughly 10 percent. So I think that is a small base on which to hang the obligation for the financial stability of the industry.

Second, if you use Medicare dollars to subsidize Medicaid it actually puts the dollars in the wrong place. The facility would get more dollars to the extent it has more Medicare patients and a larger proportion of Medicare patients, and therefore a smaller proportion of Medicaid patients. So you're sort of misdirecting the subsidy.

And third, I'm concerned that if the federal government takes on responsibility for the stability of the industry basically that says to states, you can go ahead and cut the Medicaid budget, Medicaid rates for these services, the federal government will make up the difference and, by the way we'll do it without a match. I don't think, particularly in the current fiscal environment, that's the signal that we want to send to the states about Medicaid rates.

So I'm just not sure that this is a policy, a federal policy, that would lead to the place we want to be.

MR. DURENBERGER: Just very quickly.

On the first, and you're right we have talked about this before. On the first -- and my experience goes from back in the '80s when we tried to correct all of this problem with regard to long-term care and we were doing very little if anything in long-term care to the present -- where I think whether it's 10 percent or 12 percent or whatever the percentage is, the marginal dollars makes all the difference in what a facility can do it terms of response.

Secondly, and this I get from people who are both in the Medicaid program, I guess, and in the skilled nursing or long-term care particularly side of skilled nursing, that where the Medicare reimbursement level is reasonable -- let's not say, I don't know how else to express it, but it is at least at break even or slightly better. There is an incentive on the part of the skilled nursing facility to offer and to seek out patients for this intensive post-hospital, the Medicare short stay. I just happen to think that's good thing. I think it is good for people to seek that business because I believe that people are better served in the skilled nursing facility than they are served in a hospital. I tried my best to say why I believe that earlier.

I know that experience will tell us that some of the people, if you make a conscious effort to do this, some people are going to be able to go home. This is not just all hospital or people

who are going to stay in nursing homes. Some people are able to be treated properly in the post-acute period and they're able to go home and it lessens the amount of money that they spend down into the Medicaid program.

Then finally, I just find it hard to believe that the Medicaid programs, I mean the governors and the states and the legislatures, are going to -- I mean, they've got enough other clever ways to cheat on the system to get more money than responding to a 2 or 2.1 percent increase in the SNF reimbursement level.

MR. FEEZOR: Thank you, Glenn.

I guess I share Dave's concern and compassion, and yet, as I had mentioned in the last meeting, I have a real concern about Medicare as you do subsidizing -- it's sort of the tail wagging to dog to some extent.

Having said that, I am very, very concerned about the timing, and maybe it's coming from a state where we have a 35 percent budget deficit, of some of the what I call spike factors like labor costs, workers comp, professional liability coming at a time where both states are going to be reacting and we may be taking some recommendations separately.

I guess that causes me to, at a minimum suggest, urge -- and I think there is both in the staff narrative as well as some other input that I got -- that I'd like for us to consider urging the secretary or CMS to at least try to make sure that the marketbasket or its forecasting error is more accurate, is one item.

MR. HACKBARTH: I sort of assume it's a baseline, that they are trying to make it is accurate as possible but forecasting is always inevitably --

MR. FEEZOR: I just got -- because I did not get the issue briefs since I was in an extended en route, but I was looking at language that basically said that in fact if the forecasting error had been made up that the current SNF payments are 3 percent lower than they would have been if CMS had been able to go back and correct the forecasting error. And as I have said consistently, I am very concerned about some of the input factors, how quickly they make their way into, in fact, the basis by which we are doing forecasts.

MR. HACKBARTH: Let me see if I can put this in context and if I do a poor job, Mark or Susanne and Sally, help me out.

CMS says that their forecasts have not been perfect. That's not a shock, that's usually the case. And they've quantified the magnitude of the error by looking back.

In our payment adequacy framework, as opposed to going back and correcting for forecast error which is something we used to try to do, we say well let's just look at the end result, look at the margin and see what the bottom line impact of that error is. So we project the average margin for the freestanding facilities at 11 percent for 2003 on their Medicare business even after this error.

So to say well, they have 11 percent margin, now we need to go back and add money to correct for a forecasting error wouldn't make sense. And so that's why we don't specifically recommend corrections.

MR. FEEZOR: I guess my comment is less to try to justify the money as it is making sure that we have appropriate measure in terms of what that baseline should be, just some clarification if there's some elements of it that are changing. That was my intent.

DR. REISCHAUER: But I think what Glenn is saying is that the baseline should be what we believe adequate payment level to be. And if CMS badly underestimated the increase in costs but other events, such as improvements in productivity or structure of the industry or such to maintain adequate margins, we'd say well, it worked out okay even though we started off, in a sense, on the wrong foot. It's sort of a difficult process to go through, I think.

But you can't get back and correct for every mistake unless there are consequences of those mistakes on quality, access, whatever.

MR. HACKBARTH: Sheila, and then what I'd like to do is move on to the next step of trying to resolve the issue and reach a recommendation.

MS. BURKE: Just briefly back to the issues that Dave raised in terms of Medicaid and the creation of a subsidy.

I recalled, and I asked Mark and had him double check with the staff, QMBs and SLIMBs are, in fact, paid under Medicare rates, I mean as Medicare eligibles. So in effect, there is a direct subsidy.

DR. REISCHAUER: Dual eligibles, everyone is if they're a Medicare patient.

MS. BURKE: Exactly. So there is inherent in that a subsidy that occurs. And the whole point of it is to allow Medicaid, in a sense, to buy into the Medicare program and, in doing so, essentially use Medicare rates.

I agree with Glenn's concern. I mean, I am sensitive to the issues being faced by the states, and this is an age old battle between Medicare and Medicaid. But I fundamentally don't believe that Medicare ought to be subsidizing Medicaid in ways other than explicit decisions to do so like the creation of programs like QMBs and SLIMBs where we buy in.

Yes, it is a small percentage but I do think that the fundamental policy is a solid one and I think we need to deal with Medicaid's problems in the context of the Medicaid program. We ought to be certain that the rates are sufficient in the Medicare program. And to the extent that they trip over into that population in that way, in fact, there is assistance provided to the states in that context.

DR. REISCHAUER: Even if we wanted to address the problem that you raise, I think Glenn's second point was really the killer argument. And that is by increasing the payment to SNFs,

you're going to disproportionately affect those SNFs that least need the adjustment.

You had two SNFs, one which was 80 percent Medicare, 20 percent Medicaid and another which was 10 percent Medicare, 90 percent Medicaid. You know, nine times more, eight times more would be going to the SNF that had 80 percent of its patients in Medicare and only 20 percent in Medicaid, the one that wasn't affected by the low Medicaid rates as tellingly as the other one was.

So you'd want to design some kind of DSH payment or some other mechanism for addressing this problem.

MS. RAPHAEL: The only factual point here that I do think needs to be modified is our assertion that the need for capital is close to zero through 2010. In my experience while maybe there aren't going to be new construction endeavors, there is a lot of renovation and modification going on in the industry, partly because some of the nursing homes now have to compete with assisted looking in their regions, et cetera.

So I think we just need to modify that part.

MR. HACKBARTH: I think that's a good comment.

Okay, let's turn to what we do. Again, the context for this recommendation is, as I see it, we're in a very similar place as to where we were last year. With regard to freestanding SNFs, the margins are projected to be about the same, if anything a little bit higher. Last year our recommendation in that context was no update because there was more than enough money available for the freestandings and again this year, that's the recommendation, no update in that context.

The tact is a little bit different with regard to the hospital-based SNFs. We reiterate that we think that there is an issue with regard to the payment classifications and underpinning for certain types of patients as opposed to just a categorical increase in the rates for hospital-based SNFs. We're advocating instead that the dollars follow the patient type, wherever they end up, whether it's freestanding or hospital-based which I think is consistent with our general philosophy in the past.

The issue that's been raised there is can it be executed quickly enough, and Nick raised that.

So as I see it overall we're in very much the same place as last year, just a little bit different approach on hospital-based.

I've heard three proposals for change. One, Nick's proposal that we add some language recognizing the possibility that the reallocation of the dollars may not happen quickly and we need to say that this is an urgent matter and address the possibility that it doesn't happen fast enough.

Second, we had David's proposal that the language about reallocation, drop the as appropriate qualification which seems to water it down a bit, I think was the gist of David's concern.

And then third, we have Dave Durenberger's proposal that we have some small increase, not a zero update, for the freestanding

facilities.

What I'd like to do is go through each of those proposed changes one by one, beginning with Nick's proposal.

There are two ways, Nick, that we could address this issue. One is to alter the language of the recommendation and make it still longer. It's already very long, uncharacteristically long for our recommendations. The second alternative would be to really pound on this nail in the text and say that we do think that this is an urgent matter and if, for whatever reason, this approach can't be done quickly we need to address the needs of the hospital-based SNFs where we think that there is a systematic classification problem.

Would you feel comfortable with a paragraph in the text on that issue? And obviously you'd have a chance to review the text, as would all the commissioners.

DR. WOLTER: I'd be comfortable with either approach.

MR. HACKBARTH: I sense that there's a consensus on this issue, that this is an urgent budget matter and important. I personally think it's the sort of thing dealt with more readily in the text, as opposed to expanding already long recommendations.

MS. BURKE: Glenn, I just want to make sure that I understand the import of what we're saying. Are we, in fact, saying that in the absence of an ability to respond to the recommendation of reallocating the 6.7 that we recommend an increase in increase in the update for hospital-based? Are we, in fact, saying that?

MR. HACKBARTH: That's what we would be saying.

MS. BURKE: Then we ought to say that.

MS. DePARLE: I agree. I think it should be in the recommendation, not in the text. Because the text is already very strong on the impact on hospital-based. So if that's what we think, we should say it in the recommendation, even if it makes it an extra few sentences.

MR. HACKBARTH: The reservation I -- go ahead, Bob.

DR. REISCHAUER: Maybe I'm misunderstanding it, but one is budget neutral and the other isn't. Am I right? And so we should be aware that.

MR. HACKBARTH: That is a material difference.

Part of my reservation about changing the recommendation is I do think the best approach is to have the dollars follow the patients and do the reallocation on a budget neutral basis. And I don't want to make it more convenient to say oh, we're not going to do that difficult reallocative work, we'll just take the other part of the recommendation that we like, which is add new money.

I think that this should be dealt with as a reallocation issue.

MS. DePARLE: I agree, but I think we have to be realistic about what is possible. It will take a change in law to even allow the secretary to do this, and then I think -- Mark or

someone else here, won't it take a rulemaking process, at the very least, in addition to some analytic work? So I think the likelihood that this can be accomplished within 12 months is low. Sheila? Am I being too strong?

MS. BURKE: That's my concern. But that's the reality.

MS. DePARLE: So if that's what we're really saying, I mean I agree, Glenn, from a policy perspective. But just looking at this coming down the road, I don't think it's realistic to think that it can get done in a year, given that it requires a change in law and administrative process.

MS. BURKE: Simply that. I don't think we disagree with the policy direction you're taking at all. And if there's a way to say that clearly, that that is our strong policy preference. But hell, they can't even organize the committees yet, let alone pass statute.

So I worry about the timeliness of this and being able to actually deal with the issue that's been raised, which is the treatment of particular facilities. But I think anyway we can say what you're saying in the strongest possible terms, this is in fact, what we believe is the right policy, is fine. I just worry about the timing.

MR. HACKBARTH: Could I just ask for a show of hands on this and see how many commissioners would like to see this addressed in the text of the recommendation as opposed to the body of the report?

So was I clear? I'm sorry if I garbled that.

So in the recommendation language, as opposed to in the body of the report. It looks like a majority would like that.

To have the actual language. I'd prefer not to try to wing it and give staff a little opportunity to work on appropriate language. And so I'll ask that that be brought back as quickly as possible. I'll let you work out with Mark, Sally, whether it's tomorrow or later today.

MR. SMITH: Just a quick thought about how to do it.

Perhaps we could deal with the length problem by making this is a second recommendation that should Congress fail to give the secretary authority or should the secretary fail to accomplish the work, an update -- and we could probably use the word temporary and tie it to the reallocation getting done, but an update for hospital-based SNFs should take effect on October 1.

MR. HACKBARTH: The third outstanding proposal was Dave's, that -- I'm sorry, I did skip over as appropriate.

David Smith had suggested that the language in the recommendation about reallocation drop as appropriate. Could you put that one up, Susanne?

So in the second bullet point there, the as appropriate at the beginning would be deleted. Is there a sense that that makes sense to do? I think that's good.

I see an lot of nodding heads. We don't need a show of hands on that one.

And then last was Dave Durenberger's suggestion of a small

overall increase.

MR. DURENBERGER: Let me just say before that, the issue that both Carol and I spoke to, which is the way in which the demand for capital is portrayed in the text. This isn't part of our recommendation. But the idea that lack of demand indicates a lack of need, I don't think is realistic.

MR. HACKBARTH: I think that's a good suggestion. We need to rework the language.

MR. DURENBERGER: There are at least two of those quotations in the text that I'd like to see changed.

MR. HACKBARTH: So we will rework the language on the need for capital.

On the proposal for -- I think your term was a small increase, Dave, do you want to say anything?

MR. DURENBERGER: 2.1 percent, whatever it is, marketbasket minus productivity.

MR. HACKBARTH: Could somebody on the staff help me what that number would be? What's the projected increase in the marketbasket

DR. SEAGRAVE: The current projected increase in the marketbasket for 2004 is 2.9 percent and I believe that we how, from overall multifactor productivity in the economy is .9 percent.

MR. HACKBARTH: So it would be a net increase of 2 percent.

So the next question on that's, under your proposal Dave, an across the board increase for all SNFs, and then there would be, in addition to that, the reallocation proposal that we reallocate the dollars for the certain types of patients. Is that correct? Is that what you intend?

MR. DURENBERGER: Yes.

MR. HACKBARTH: So why don't you put draft recommendation one up there, Susanne. That one would be amended to read marketbasket minus productivity, which turns out to be a net effect of 2.0 percent.

Could I ask for a show of hands on that? Who's in favor of that change in recommendation one?

I think we've dealt with all the proposed changes. Should we now proceed, we can vote on draft recommendation one. And two, we'll need to come back with some amendments, right? So why don't we vote on one?

All those opposed to draft recommendation one as worded on the screen?

All in favor?

Abstain?

And then we'll bring back two.

DR. SEAGRAVE: There's a third.

MR. HACKBARTH: That's right, we do need to do number three which is -- would you put that up on the screen please? This is the recommendation for the continuation of the access studies.

All opposed to number three?

All in favor?

Abstain?

Okay, and we look forward to seeing the revised language on two.

MS. BURKE: Glenn, just to underscore, it's not in the recommendations but it essentially links a third, which is the nursing issue, to make sure that we make some note in the text about our desire to look carefully at this shift to non-RNs and impacts on quality.

DR. STOWERS: Glenn, is two going to change and be modified or are we going to have a separate recommendation?

MR. HACKBARTH: I'm certainly open to a separate recommendation. What I'd suggest is let's just let the staff look at it and see what is the clearest way to present it, whether it's in a revised single recommendation or a separate new one.

Next on the agenda is home health services. Sharon, whatever you're ready.

MS. CHENG: This presentation is the last in a series of three in applying our payment adequacy framework and making update recommendations for the home health services.

At this meeting, I will percent an estimate of the current Medicare margins for home health agencies. I'll discuss a new indicator of quality, discuss changes in the use of the benefit, and also review very briefly some market factors that we've discussed at previous meetings.

Finally, I'll present proposed recommendations for your discussion and vote.

Again, this slide, to just get us oriented, the home health sector represented $10 billion in Medicare spending in the year 2001. There were about 2.2 million users of the benefit in that year, and there were about 7,000 home health agencies.

This bar graph represents the trends in home health spending over the last 10 years. About 10 years ago, home health spending started a period of growth. Between 1990 and 1996 there was an average annual increase in spending of 33 percent. It reached its high point in '96-'97, and from 1997 to 1999 fell about 50 percent. You can see it's about level between 1999 and 2000. And in 2001 spending started to grow again.

The Congressional Budget Office has projected the spending on this benefit will continue to grow over the next five years. Last March that estimate was 17 percent average annual growth over the next five years. However, CBO has indicated since then that they will revise that estimate downward. The new estimate of growth, along with their underlying assumptions, will be included in CBO's report out in March.

Like spending, use of the benefit has been up and down over the past 10 years. Changes in eligibility for the benefit, enforcement of program integrity standards, and the structure and incentives of the payments system have accompanied those changes.

Use of the benefit grew 85 percent from 1990 to 1996. The factors that preceded that growth were a loosening in the eligibility for the benefit, a legal decision that made enforcement a bit more difficult for HCFA, and the incentives of the payment system to maximize the number of visits delivered.

Under the IPS, use of the home health benefit fell by about 1 million users. Again, the changes that preceded that trend was a slight tightening in eligibility, the implementation and the effects of Operation Restore Trust, which was not limited to the home health benefit but was a factor in the home health benefit, and it prompted several hundred involuntary closures of agencies over that period.

And also the incentives of the payment system changed again so that there was an incentive to maintain a relatively short stay and low cost patient mix.

Since PPS, spending has begun to grow once more but the number of users continues to decline, albeit it at a slower rate. With the implementation of the PPS, again there was a very slight loosening of the eligibility of the benefit. There is still medical review and there still are some involuntary closures of agencies.

But the structure of the PPS is very different again from the IPS. The PPS features case-mix weights so that the payment is adjusted to reflect the clinical severity and the functional limitations of the patients being cared for. Also, patients can receive multiple episodes, so long as they remain eligible for the benefit. And there is an outlier policy that removes some of the risk for very costly patients, although it has been noted that the outlier policy is underutilized.

Looking at the underlying structure of the PPS, along with our analysis of the relationship between cost and payments, it does not appear that the structure of the PPS nor the current level of costs and payments are the sole barriers to increasing growth and utilization.

Those trends in spending and use provide important context as we move into the payment adequacy framework and its next phases. One important part of our adequacy framework is the assessment of the relationship of current payments and costs. We have three different analyses that we're going to take together: GAO's analysis, Medicare's financial margins, and the payment-to-charge ratio.

As you recall, GAO found that the average episode incurred reimbursement of $2,700 and incurred costs of $2,000. That different represents a payment 35 percent greater than the cost on an average episode. The Medicare financial margins, I'll go into more detail in just a moment.

The payment-to-charge ratio, we have discussed before, but in response to some of your questions we've disaggregated it to use that to look a little bit more closely at the financial status of rural home health.

These margins are for Medicare freestanding home health

agencies. They're based cost reports from 10 percent of the agencies in the program. That is to say those with post-PPS cost report data. It is a non-random sample. However, it is roughly proportionate to the nation in terms of the mix of voluntary, private, and other types of home health agencies and the urban and rural mix. It is not geographically representative.

The overall margin that we estimated for 2003 takes into consideration the impact of the so-called 15 percent cut and completely phases out the add-on for services provided to beneficiaries who live in rural areas, even though that add-on will expire halfway through 2003. The overall margin that we arrive at is 23.3. That's slightly different that the number in your handout.

There is some variation within our sample. Private home health agencies have a slightly higher margin than voluntary. And rural, reflecting the impact of the phase-out of the add-on, have slightly lower margin that urban agencies.

As would be anticipated in any new payment system, there are some distributional and structural issues that may require adjustment. CMS does have plans to refine the PPS has data becomes available.

Our estimates of the margins for hospital-based home health agencies are lower than those for freestanding home-health agencies. When the hospital-based home health agencies are included, therefore, the average for home health in the sector would be somewhat lower.

The estimate for hospital-based home health margins may tend to understate their current margins for two reasons. They include pre-PPS data in the base year and the freestanding home health agency margins do not include pre-PPS data in the base year.

Secondly, there are issues with cost allocation within a hospital that would tend to affect all non-inpatient lines of service at the hospital. Including those somewhat lower hospital-based home health agency margins would decrease the all agencies 2003 margin to about 17 and would decrease the rural margin specifically to about 9.

The second piece of evidence that we have regarding the relationship of payments to costs is the payment-to-charge ratio. We've looked at the all episodes numbers before but we've gotten some commence on this and I'd like to elaborate on it a little bit.

Before PPS, Medicare paid by the visit the lesser of cost or charges. And given that incentive, we can assume that costs were lower than charges.

In 1994, the ratio of payments to charges was .74, and in 1997 was .73. Though we switched the unit of payment under the PPS, when an episode contains four or fewer visits, it's paid by the visit just like it was under the previous payment system. And that's a LUPA episode. As you can see, the payment-to-charge

ratio for LUPA episodes of .75 is about the same as it was in 1994 and 1997. This is evidence that the charges have kept pace with changes under the new payment system.

We took advantage of the somewhat larger sample that we have in this payment-to-charge ratio to disaggregate by urban and rural. Here we are able to disaggregate it by the location of the beneficiary, which is how the add-on is calculated. We think this gives us a somewhat better look at the rural situation.

That analysis provides evidence that both rural services in the aggregate and subgroups within rural areas are being paid adequately as all rural groups had a payment-to-charge ratio greater than one. This evidence, along with the margins that we've just discussed in GAO's analysis, suggests that payments are currently more than adequate for this sector.

When analyzing a sector that has had as large a product change as we've discussed at past meetings, we would like some evidence that despite this product change, quality has not declined. So we've taken a look at the quality of care and what we know about it since the PPS. CMS was aware of the incentives of the new payment system and implemented quality measurement and improvement along with the changes that it made in the payment system.

Home health agencies are required to collect outcome assessment information at the start of care and the discharge of care. This is the OASIS dataset. From that, CMS develops outcome reports, case-mix and adverse event reports which are fed back to the agencies, so that they can implement their own process level quality improvement.

CMS also plans soon to implement a reporting system that would allow consumers to use this quality information to choose high quality home health care providers.

One trial conducted by CMS of this process of collecting outcome measures and providing reports back to the agencies decreased hospitalization statistically significantly compared to a control group and increased improvement in clinical and functional outcomes, again statistically significantly more often than the control group.

We've also taken a look at an index of quality outcome measures that has been collected. This index includes decline, stabilization or improvement in patient clinical severity or functional limitations and was measured at the beginning and the end of the first full year of the PPS. This index has remained relatively stable and has shown no decline in quality over the first full year of the PPS.

The index was developed by researchers at Outcome Concept Systems which is a private firm that collects data from about 700 Medicare certified home health agencies. The index itself was based upon 350,000 patient episodes of home health care. Participating agencies in this benchmarking agency's private sample include a cross-section of the sector geographically and by type of control.

The stability of this quality index provides some evidence that quality has not declined under PPS despite the decline in volume of visits and the change in the product. This provides evidence that productivity has improved and that costs, as we see them now, are appropriate.

As a final step in the first phase of the payment adequacy framework, we've also included other market factors. We've looked at these before to just briefly touch on them, the home health product has been changing. We've seen declining visits per episode, declining length of stay, fewer home health aide visits as a proportion of all visits and a greater proportion of therapy visit.

Entry and exit of providers has been stable over the past three years. We do know that about 200 agencies exited last year and about 300 entered. So not only has the total remained relatively stable but the amount of churning under that total is relatively small.

The number of agencies is not, nor has it ever been, a measure of the ability of the system to care for home health users because it fails to capture any meaningful information about capacity. For an industry without much investment in bricks and mortar, capacity would best be measured by an index of personnel available. When one home health agency closes, its personnel may be able to easily move to another agency. So though it would register as a closure, there may be effectively very little or no impact on the capacity to care for Medicare beneficiaries in that area.

Our third market factor is beneficiary access to care. We used our hospital discharge planner panel and the OIG survey, and both of these concluded that beneficiary access is generally good. MedPAC is developing additional resources to provide more information on access to care. Our episode database will be able to track patterns and changes in home health use by beneficiaries referred from the hospital as well as beneficiaries referred from the community or from a skilled nursing facility.

The OIG's work, or a study similar to it in methodology and sample size, however, will continue to be an important adjunct to the work that we can do in our understanding of beneficiary access to this benefit.

I'd like to touch on one final issue in this portion of the payment adequacy framework, and that's IPS repayments. Under the interim payment system many home health agencies received greater payments than they were due under the limits of the system, thus generating debts to Medicare for the difference. When the amount to be repaid was large, the program extended repayment plans and some of those repayments are still being made today.

Agencies were overpaid because they did not know what the limits would apply to their payment until they closed their books for the year, the costs were analyzed, and the limits were retrospectively determined. Overpayment was prevalent. In the last full year of IPS, about half of all freestanding agencies

had some overpayment from the Medicare program.

Since then some home health agencies have left the program and some have repaid their debts. However, we've been asked to look at this issue because for some agencies, IPS repayments continue to be an important factor in their financial stability.

CMS has taken some steps to reduce the stress of IPS overpayments. They have extended the repayment schedule and they have lowered the interest rate for repayment of this debt.

With that, I'd like to move to the second phase of the framework, which is anticipating cost changes over the coming year. Staff conducted an analysis to determine the impact of declining visit volume on costs. The results of that analysis determined that costs per episode fell from 1999 to 2001 by 16 percent. The decline over the course of 2001 was 5 percent.

Taking into account then the steep decline that preceded the PPS as well as evidence that the decline continued at a slower pace under the PPS, our evidence suggests that costs will continue to decline.

To apply our framework then, we bring this anticipated cost change together with our assessment of payment adequacy to make our recommendation for the update. Before proposing our update recommendations, I'd also like to respond to some questions that we've received regarding rural home health, just to make sure that I've addressed the concerns that we've heard. Staff believes that costs per patient could be higher in rural areas than in urban because many rural agencies have a very small scale of operation. The distances to travel upon rural clients could be great and there are differences that we've observed in the use of therapy between urban and rural providers. At this point in time, our analysis of margins cannot determine the cause of the difference in Medicare margins between urban and rural agencies further than the factors that we believe to exist. This leaves us, on the one hand though variations among margins for some rural agencies and the observations of some of the members of our discharge planner panel may lead us to conclude that continued special payments for services provided to rural beneficiaries are appropriate.

On the other hand, evidence from our analysis of the payment-to-charge ratio, which has a larger sample than our margins and is somewhat more recent data, tends to contradict this conclusion.

Thus, the need for continuing the add-on for rural payment is not precisely clear. In current law the add-on will expire April 1st, 2003. The commissioners may consider taking no action, thus they would allow the add-on to sunset. Alternatively, commissioners may choose to phase out additional payments and a possible phase out is one of the proposed recommendations that I've brought for our consideration this morning.

Draft recommendation one addresses the update. Congress should eliminate the update to payment rate for home health

services for fiscal year 2004. Our analysis has included the impact of the 15 percent cut and the phase-out of the rural add-on. With these two factors included, we've analyzed claims data from the PPS system and cost report data to find the current relationship between payments and costs.

This analysis, again taken together with the GAO evidence, suggests that payments are more than adequate. Looking at anticipated cost changes, we believe that costs will be declining over the coming year and market factors are generally positive.

The budget implications of this recommendation, since current law provides a full marketbasket update for the base payment home health services, would decrease spending relative to current law in the category of between $200 million and $600 million for fiscal year 2004 and between $1 billion and $5 billion over five years.

Draft recommendation two addresses the rural add-on. This proposed recommendation states that Congress should extend for one year add-on payments for home health services provided to Medicare beneficiaries who live in rural areas at a lower rate, for example 5 percent. The current add-on is 10 percent and is scheduled to expire on April 1st. This recommendation, we would propose to extend the add-on one year from April 1st.

At 5 percent, which is the suggestion in the proposal, this would increase spending compared to current law in the category of between $50 million and $200 million for fiscal year 2004 and less than $1 billion over five years.

Finally, our draft recommendation three addresses the series of nationally representative samples of Medicare beneficiaries' post-hospital discharge access to home health services. This is in parallel to the recommendation that we made earlier for the SNF, the two series are parallel. The budget implication, we believe, would have no benefit spending impact.

That's the package of recommendations. At this time I invite your discussion.

DR. STOWERS: Sharon, it's a good chapter. I just had a couple of questions.

When you talk about the charge-to-payment ratio for rural being 1.16 or whatever, and therefore adequate, does that take into account the volume problem? I know once the nurse gets out to the rural site for that visit, the charge-to-payment ratio is appropriate. But would it account for the fact that because of distance they could only see two or three patients that day, as opposed to five or six or seven?

MS. CHENG: That payment-to-charge ratio does address the issue at the claims level. So we're looking at episode by episode how does the payment relate to the charge and presumably to the cost. It cannot address what could be a difference in productivity between an urban-based nurse and a rural-based nurse.

DR. STOWERS: And there's no reflection in costs for mileage

driven or time, the productivity things.

MR. HACKBARTH: The assumption would be that the charge structure reflects that.

DR. REISCHAUER: That shouldn't be an issue.

MS. CHENG: The same assumption that we make for the overall analysis would hold. We assume that each agency has set its charges above its costs. So if the rural agency had a higher cost, then it would have a higher charge, right.

DR. MILLER: Could I add just one thing to this, just before we get off it? In the margin analysis, you are taking account of the volume changes and the change in the product. That's why we're trying to present both pieces of information.

MS. CHENG: Right, we're sort of trying to triangulate there.

DR. STOWERS: That makes me feel a lot more comfortable about that.

My second thing is the use of the term total phase-out. I'm not so sure I'm uncomfortable with let's say going from 10 to 5 percent or whatever, but I think there's some permanent environmental things like distance and that kind of thing that may remain over a long term in the rural world that may not change in a year or two. So I'm not sure we're ready yet, as a commission, to say phase it out all together. I can see trying to find a more appropriate level for it. Just an editorial comment a little bit on that.

DR. REISCHAUER: I thought what we were hoping was that new data would come in and reveal whether these cost differences are real and are significant. And if they are, then we as a commission would make an appropriate recommendation that there be some kind of differential payment.

Sharon, am I right that on the material that you represent and in the chapter here, the 2003 estimate assumes that the rural add-on for the margins disappears completely? And so, if we were to maintain the 5 percent add-on for 2004 the margins for urban and rural would be more or less similar?

MS. CHENG: That's right. The estimate in 2003 phases it out entirely. So you're seeing, hopefully, an estimate of the full impact of no add-on. So you can look at that and get a sense of what 10 percent higher payments might be.

DR. REISCHAUER: Or 5 percent if we went with our recommendation and it would then wash it out.

MR. HACKBARTH: Let me just try to nail down this point about the rural recommendation. Could you put it up there, Sharon?

Actually, to my eye at least, this does not look like a recommendation of a phase-out, but more in line with what Ray was describing that we don't have the basis for eliminating it. And right now we're recommending a one year extension at a lower-level until we get additional information.

If you really meant to say phase-out, you would say we plan to phase this out over such and such a period and that means a

reduction of this amount. So I think this language is actually consistent with Ray's objective.

DR. STOWERS: I'm okay with the language.

MS. RAPHAEL: First of all, I want to thank the staff because I think they've tried to be very responsive to some of the concerns we've raised last time, trying to see where we might have some information on quality and outcomes in a field of now very limited data. I think they've really fished every pool available here.

I have a couple of comments to make. I would urge caution in this area because I think that we still do have limited data and knowledge. And while we're talking about averages, I think the effects and the results do vary very understandably by location, by size, mix of patients. And we don't really happen very, very good information about the variation.

We know that visits per episode continue to vary dramatically geographically from 13 on average in Washington to still Louisiana being number one with 58 visits per episode. We also know that the industry is comprised of public agencies, 13 percent are public agencies that often are very much influenced by what's happening in their counties. 38 percent are hospital-based agencies, and there are many caveats there but the margins there are very shaky. And certain 14 percent are not-for-profit and I know among some subset they really handle 50 percent of the dually eligible and a large part of whatever uninsured and charitable care is provided to the home care population. And unlike the nursing home sector, the home health sector is more like hospitals. I think about 28 to 38 percent of their revenues derives from Medicare. In some cases, for some agencies, it's up to 70 percent of their Medicare. So what we do here can be very influential.

I see a number of warning signals that I just feel we need to pay attention to. The first is the drop in beneficiaries which has been just substantial, 1 million beneficiaries dropping out. And even, as Sharon pointed out, in the last year I think there was under PPS another 300,000 beneficiaries dropped out. The decline continues, albeit it at a slower level.

I'd like to put this decline in some context. First of all, every other sector of Medicare that we're looking at as a commission shows increase in volume and use. I went through our entire report here and did a little chart for myself to look at what's happening with physician utilization, what's happening with nursing home utilization, to see what's happening with hospitals. And interestingly enough, hospital discharges are growing up in the range of 3 to 4 percent per year and home health care -- I mean, I think in the chapter on transfer payments we say about 30 percent of hospital cases go to post-acute and about 9.7 percent go to home health care.

So everything here should be leading us to have more beneficiaries because we know more are coming from nursing homes to home, more are being referred by physicians, and more coming

from or should be coming from hospitals as their discharges go up.

In our chapter three, which I thought was a very good chapter, we conclude in terms of demographics that the population over 85 has grown in the last decade by 47 percent and we say that seniors over 85 use a significant amount of home health and SNF services. And at a much faster rate we expect growth in those two areas than we do in fact in the future in physician and hospital services.

We talk about the minority population growing. African Americans over 65 have increased in the last decade by 18 percent. Over 85 African-American population has increased by 43 percent. We say, and I quote, "two services are of particular importance to the current minority population, emergency departments and home health use."

I won't go into all the issues on the prevalence of chronic illness and what has happened in that realm, what's happening in medical practice. Nonetheless, all of the demographic and health status indicators should lead to more beneficiaries using home health care. Put aside the payment system, I'm putting that aside for right now. So this is very, very puzzling.

The other comment I want to make here is I feel very powerfully that there isn't a world of pre-'97 and post-'97. People are the same, they have chronic illnesses with acute exacerbations. And then it subsides. While we might have changed how we're interpreting the benefit, people generally have the same needs today that they had pre-'97.

So I don't think it's as if we have kind of really changed the population. I think there are people who have short-term kind of very intense needs, and there are people who have longer-term sort of more attenuated supportive needs today as existed in the pre-'97 population.

The thing that I just cannot understand is why there aren't more admissions because the whole prospective payment system should lead you to increase your admissions. That's the incentive that we have set up. We see that one of the incentives is working, which we had expected, that visits have decreased. But the other incentives are not working. Why don't we have more admissions? The LUPA incentive, as we had predicted, has not come to pass. We thought there would be very few LUPAs and a real impulse to move toward that episode. That hasn't happened.

Outliers, we had thought would be at 5 percent, they're at 3 percent. There aren't as many second episodes as we might have predicted. So something to me indicates that something is happening here that needs attention and that we should be mindful of going forward.

In fact, and I recognize that growth patterns, like home health care has the most astonishing changes in patterns here. But if you look from '91, 6.5 percent of the beneficiaries use the fee-for-service home health care benefit. In 2001, 5.5 percent are using the home health care benefit. So just trying

to take out all of the volatility, we have less people today using the home health benefit than did 10 years ago and I'm trying to understand why this is.

And then the other point that I did want to make and, of course, I find this hard to reconcile with a 17 percent growth rate which you said that CBO is going to modify. I do believe and I can't prove this, but I do believe there are some access issues. I do believe there are two things happening out in the marketplace.

As you said, Sharon, the operative thing here is not the number of agencies but you said we need a personnel index. And I do believe capacity here is people. And most agencies have a 15 percent nursing vacancy rate. And that means that they can't admit people because the whole OASIS system is based upon, at the gate, a nurse being able to do an assessment. And that really is your day-to-day capacity.

So I think there is a lack of capacity to meet the need for services here and that's one of the things that's causing a shrinkage.

Secondly, I do believe there is more selectivity. We don't know the distribution of cases. We don't know the wound care cases, we don't really know how many are what I would call complex care cases. I do believe that patients who are incontinent, have cognitive impairments, don't have a caregiver, are more of a burden, are the ones who are being selected out of the system. I can't prove it, I don't have the empirical evidence, I'm putting together an amalgam from my own expense. I think that is what is going on.

And I don't think that augers well for the future because what I would like to try to think through with the other commissioners is what are we setting in motion here for the future? Because home health care organizations can't really substitute lower cost services for higher cost services, to a large extent. You can't use LPNs -- this is my experience -- I can't substitute LPNs for nurses. In fact, I need more skilled nurses today than I ever did before, given the complexities that we're facing.

The mix of services is interesting, because you saw that the lower cost services, aide services, in fact have dropped and it's the higher cost services, the professional services, that are composing more of the mix. It is hard. I have been a great proponent of the prospective payment system. I really believed it was very important but it has been hard to achieve some of the productivity we had hoped for because visits are taking longer for a variety of reasons.

So where does this leave us in the future? My worry is as we take dollars out, and I recognize what you're showing on the margins and the GAO report compared to our Medicare margin report and all that you have constructed here shows that we are paying more for an episode of care than it is costing providers to deliver it. So I recognize that.

However, where are we going? Because if we drop what we pay, what will agencies do? I think they will begin to do two things. They will bring visits down even more and they will be even more selective in terms of the types of patients that they take. I'm just worried, are we setting in motion here a spiral which will end up hurting access for some of the most needy and frail Medicare beneficiaries?

So that kind of leads me to think I'd like to just discuss this a little bit and think through some other recommendations that we might make here that could help at least to address what I consider the worrisome issues that are at least keeping me awake at night.

So thank you.

MR. HACKBARTH: Carol, could I ask a question?

You've raised some I think widely held concerns or at least questions about what's happening to the number of users and clearly we can't answer those questions definitively. But what I'd like to focus on for a second is what is the appropriate policy response in the face of the uncertainty.

The thing that I have problems with is that when you look at the average margins, look at the data that we get from the payment-to-charge ratios, look at the GAO analysis, it looks like there's money in the system. Maybe because this is a new system, it hasn't been refined enough to get to all of the right places exactly and I'm sure we do need some more work on that. That's always been part of implementing a new PPS system. There's a period of refinement so that you get the dollars to the right places.

But to say that in the face of 20 percent average margins, which are true pretty much across the board, we're not seeing a lot of variation in that, that the appropriate policy response to the uncertainty about the reduction in users is still more money into the system.

Why will that work? Why will that help with the decline in users? There's plenty of money in the aggregate there. If we just put more money in, what's the guarantee that it's going to solve the missing users problem if, in fact, there is a problem?

MS. RAPHAEL: I have been struggling with this whole issue of figuring out is there a way to refine the system or target so that you get to where you want to go in this system. I think you are raising a very legitimate policy issue.

But I don't think that if you put more money in you guarantee that you're going -- that this group of beneficiaries who have dropped out are more likely to come back.

On the other hand, we had 5 percent drop to the base in October. We don't know the impact of that 5 percent drop. You're taking 3.3 percent out now when labor costs are going up 5 to 6 percent. And for rurals, we could conceivably pull another 10 percent out. The cumulative effect in a two year period for some agencies could be over 18 percent. So the flip side of that is by doing that, do you then just

continue what we are seeing now or just intensify it?

MR. HACKBARTH: Just to be clear though, the projected margins here include the so-called 15 percent cut, include the effect of eliminating the rural add-in. So that's baked into the cake. This is saying even after those the average margins are quite high.

And when you compare these margins to other Medicare providers, a lot of people would say they've put a lot of money into this system to ease the transition. The payments are very high relative to costs. What more can be done at this point other than work to refine the system, not just throw more money at it.

DR. REISCHAUER: But there's a fundamental question which is whether the nature of the service is so squishy that it's inappropriate to apply a PPS system of the sort that we have for payments.

MR. HACKBARTH: That is an important issue in home health, more so than with regard to other services. But again it begs the question, would throwing more money into the pot solve the problem? I just don't see how that's an appropriate policy response.

DR. REISCHAUER: I think you're right on that, but Carol's response is will cutting back further not create more of a problem? At some point we'll get down to average number of visits is one over the lower limit and the people who are being sent out are the least skilled people we can find and Carol will come back and say that the numbers of people being served has shrunk by 85 percent and we don't know who they are, who have left the system.

DR. WAKEFIELD: It's not on Carol topic. It's actually onto draft recommendations two. Do you want me to go there, or is there more that anyone wants to say about Carol's comments?

DR. NEWHOUSE: I want to echo what was just said, both the point that what we've seen reflects the incentives of this systems and there are some puzzles about why we're not seeing more. But I agree with Carol that the incentives are to keep cutting the volume and selecting. I also agree with Glenn that tinkering with the update doesn't fix this issue. We really need a different architecture here entirely, but that's not an issue for this meeting. That's an issue for next year.

The other suggestion I have, which is also really not a -- I think at this meeting it's too late. But I think it would be helpful at some point to look at the distribution of these margins by agency, at the agency level.

You, Glenn, said that you see these high margins across the board. That's true for the means by subgroups. I'm not sure it's so true by agency. It could be that we have some agencies that are really trying to make out like bandits and we have some agencies that are the traditional non-profit ethos of carrying out, doing as much as you can with what you're given. And that may show up in a distribution at the agency level that I haven't

really seen.

But that all being said, what we're doing today is acting within the constraints of the architecture of the system and, given these margins, it's I would say even somewhat generous to conclude that there should be no update.

DR. WAKEFIELD: I want to speak to supporting draft recommendation two. I think, Sharon, it would be before your time but there was a song in the '60s that starts out -- I can't remember the singer. The opening line is something like something's happening here, what it is ain't exactly -- thank you, Crosby Stills. He's dating himself. Something's happening here, what it is ain't exactly clear.

I think we're still not exactly clear about what might be going on, at least in some of the rural health agencies.

The data that you broke down, and I should have commented on the SNF data as well, giving at least for me information about subgroups like rural versus urban and other even finer detail is extremely helpful. I know that probably takes you guys a lot of time to do. But it makes me even more comfortable with this recommendation as opposed to a 10 percent continuation and so on.

So A, I just want to say thanks so much for doing those additional cuts and giving us more clarity.

Having said that, I'd say as you pointed out, we do have discharge planners comments on this. We do have concerns around access in some rural areas. We do know that the types of services that rural beneficiaries get is not at the same level of therapy even though their severity of condition is the same as their urban counterparts. So there's enough going on with that population that it still makes me a little bit concerned. And until we get more clarity on that data, I would be in support of that recommendation.

MR. HACKBARTH: On this the particular recommendation, the inclusion of the e.g., the for example, seems sort of wishy-washy. If we want to recommend that they go to 5 percent, I think we ought to just say it and drop the e.g.

DR. MILLER: That was just for this meeting, to give you some place to start off from.

DR. REISCHAUER: After extensive statistical analysis, we've come up with 5 percent.

[Laughter.]

MR. SMITH: I want to come back to the colloquy that you and Carol had and ask Sharon to get back into it. Carol began by urging caution and I think that's right. Perhaps I don't know whether it was Stills or Nash who wrote it -- I think it was Grant Nash who wrote the song.

It's not at all clear, and Sharon said early in the presentation, and it focused what I thought as I read the materials, that we don't know what accounts for decreased utilization but the PPS doesn't account for it. And Carol suggests that, as well.

If we are concerned, as several folks have expressed, about

the decrease in utilization, this chapter doesn't say it. And I think we ought to say that. And we ought to point to a concern about the structure, the architecture, some of the questions that Joe raises, as a concern that requires some urgent analysis. We don't believe that we know enough to fix it by fixing the payment levels.

On the other hand, Carol strongly suggests that we might make it worse by reducing the payment levels. I don't know how I feel about that or what we might do in terms of a recommendation. It's awfully hard to argue that these margins don't meet an adequacy test, but there are a million people missing so something's inadequate.

It sounds like we think what's inadequate is the structure of the benefit, and we ought say that. We ought not to have this chapter conclude that the payment system is adequate without raising in a very explicit way the concerns about the inadequacy that the evidence of decreased utilization points to.

MR. HACKBARTH: Sharon, could you remind us about the trends in the number of users? My recollection, and it's admittedly not as clear as I would like it be, that we've had an ongoing decline in the number of users over a period of time, only a part of which has happened post-PPS. There was a substantial decline, in fact, my recollection is most of it occurred pre-PPS and was concurrent with things like --

DR. NEWHOUSE: No.

MR. HACKBARTH: I would like to hear what the data are on that. There was some decline that was associated with Operation Restore Trust and all that. So could you just sketch that out for us, please?

MS. CHENG: At the high point of utilization, which was 1997, the number of users was about 3.5 million. And that had fallen to 2.5 million before the implementation of the PPS. There was a substantial decline during the interim payment system in the number of users.

The decline has continued since the PPS but it hasn't been as steep as it was before the implementation of the PPS.

DR. REISCHAUER: But there were other things going on. There was a moratorium on new agencies and there was a crackdown on fraud and all of that occurred in the years before PPS.

DR. NEWHOUSE: Can I jump in? Because I wanted to make that comment on Carol's point about pre- and post-'97 people were the same, which I agreed with. But they also were presumably about the same in '93 and '97 and this utilization was going up like a rocket ship. And some of this decline we do think it's attributable to reduction in fraud, which makes it very hard I think to interpret these numbers.

DR. REISCHAUER: But I think the most interesting number actually was Carol's number that the smaller fraction of Medicare participants access home health now than in 1991 and that's a little hard to understand.

MR. DURENBERGER: There's a section on page seven under

incentives. It's at the top of the page, the first paragraph. The structure of the PPS should not represent a barrier to an increase in the number of home health users. It seems to me that somewhere right there a sentence or two could be added which would reflect this discussion so that it would come out as a warning signal about the value of the current structure.

DR. MILLER: Maybe I'll just interject for one second. As you can imagine, we've been discussing this quite extensively both within the staff and talking to people outside in the industry and in the agency itself.

Through those conversations this conversation occurred in so many words and also there were discussions between MedPAC and CMS. There's a lot of work going on at CMS right now on looking at refining the actual weights, looking at the outlier policy, and also looking at the first and second episode issue, which I think Carol referred to.

We have contemplated for purposes of this meeting bringing up the idea that maybe there was a stronger set of supporting language that could go in underneath the recommendation that says this is the recommendation. We recognize some of the variation on some of the issues here, put that, and urge that this work that is going on at CMS come out as soon as it can so that some of these issues can begin to be addresses.

MS. BURKE: I was just going to say that in addition to the actual decline in numbers, which is obviously confusing all of us, I continue to be struck by all the other stuff we don't know. And throughout this very nicely done chapter there is a continual reference to there's a change in the demand, there's a change in the nature of the service, there's a change in the mix of the things that are being sought, there's a change in the length of stay.

It's a continuum of what we don't really truly appreciate and I think Carol points out, and I think we have a responsibility to say not only in the context of the recommendations but specifically in the context of the chapter, that work needs to be done only on the issue of why are there not more number of people, but also what fundamentally is changing in the nature of this benefit?

It is a function of technology, it's a whole host of things. But it is fundamentally a different benefit than we knew it to be and I think we don't yet fully appreciate, nor can we accommodate in whatever we ultimately do in the design of the payment system, what that is.

And I think we also ought to comment on, as we go forward, additional information not only on the numbers but on who and what and why and how they're being served is going to be critical to us. Because it really isn't the same thing as it was in the '80s or the '90s. It's just different.

DR. NEWHOUSE: It may be helpful in the text also to say something about the nature to which this should be a purely post-acute benefit because that seems to me to be one thing that's

happened. It's clear in the decline of the eight visit users, it seems to me policy has somewhat shifted there from trying to accommodate what was basically some portion of chronic long term care through the mid-'90s to then this system which tries to shift back to something that really is truly post-acute.

I don't know if one can explicit direction here but it seems to me trying to frame that issue in the text could be helpful.

MR. FEEZOR: On Joe's point, I think on page 13 there sort of a reference to it about it's changing from a maintenance of consistently ill and disabled over time to that of acute illness recovery. And that raises the question, earlier this morning there was some question in terms of whether that was a deliberate policy change or not. And if so, we ought to make that very explicitly and underscore that in the text somehow.

DR. NELSON: Glenn, what I was going to say and didn't, Sheila started getting into it, but it has to do with the qualitative changes in the product, not just the quantitative changes. And that a company that's faced with the prospect of going out of business because of inadequate payments may very well change the qualitative aspects of the product in a way that isn't picked up in the quality assurance monitoring, by eliminating certain services that are labor intensive, by eliminating from their menu of services diabetes education, for example.

I think that recommendation three provides for monitoring of this. But I agree with Sheila that it's different now than it was 10 years ago and payment policy should not force it to become different in a way that's perverse, that's qualitatively perverse.

MR. HACKBARTH: As Joe correctly pointed out we're looking at average margins here and ideally we'll have in the future more information about the distribution of margins. To the extent that there are a large number of agencies losing money, and the averages is at 20 percent, that implies that are a whole lot at the other end of the distribution that are offsetting those, which is both an interesting and troubling thought.

I keep coming back to yes, there's uncertainty; yes, undoubtedly refinement is required. But will putting more money into the system when we have such high average margins be an effective response in the short run? Or is it simply necessary to do the detailed work to improve this system over time?

To me that's what's different than when we had this conversation last year. Last year we recommended a marketbasket increase for home health agencies and we were quite explicit in saying that we make that recommendation because we do not have any evidence on costs and margins. And we don't have evidence about the rate of growth in costs relative to input prices.

We do have evidence today. Not perfect evidence but we have substantial evidence today of high, very high average margins. So I think we're in a different place than we were a year ago.

My personal conclusion is that that supports the

recommendation of no update, but that we ought to state with some force and urgency the need to get on with the refinement of the system.

As I see it, that's where we are.

In the interest of keeping on time or some semblance to on time, I think we need to get to the question of the recommendations. Carol, you have the last word.

MS. RAPHAEL: I'm going to support the rural continuation even though I've seen the margin information and one could argue that the differences are very minor between urban and rural area. But my own experience is that we do have rural counties where we have one or two organizations really embedded in that community, fragile for a whole variety of reasons.

And I think we need to really try to preserve those agencies to the extent that we can because they're not interchangeable parts. If they go over the cliff there's isn't going to be a company that's going to swiftly go into that are and try to pick up to that capacity. So I'm supporting that.

I would like a recommendation on moving toward refinement in line with what Mark was saying.

And thirdly, I have problems with the last recommendation which speaks to trying to restore the surveys of post-hospital discharge planners, because to me that's sort of George Orwellian old think. We're still defining this benefit only in terms of being attached to the hospital and discharge when we know that 50 percent of the people come in from the community, from physicians, from nursing homes.

When we looked at what's happening with physicians, we did surveys of positions. I think there should be some way to do surveys of agencies or surveys of consumers and their families. I'm not saying this is easy and I know there have been problems with previous attempts at this.

But I know when you speak to agencies they will tell you what they are doing, whether they are accepting all new Medicare beneficiaries, whether they're only accepting some. I think there should be some better way to get at this access issue.

MR. HACKBARTH: So on the third recommendation, Carol, you would propose deleting the specific reference to post-hospital discharge and ask that it be reworded so that we need studies on access to home health service.

MS. RAPHAEL: Right.

MR. HACKBARTH: Do people agreement with that?

DR. REISCHAUER: I think we have to change the wording so it doesn't say continuous series.

MR. HACKBARTH: Right. Do people feel comfortable with that modification in number three?

How would you like to handle that, Sharon and Mark? Would you like to actually draft up language? That's probably the best thing for you to do, is draft it up and bring it back on number three, and we'll look at the exact language.

DR. MILLER: May I make just one suggestion? Can you put

that recommendation up there, the one that we're discussing?

I realize what you're saying and we can always put text in this. Would it be sufficient for the purposes of the recommendation and just moving on to strike post-hospital discharge and say studies of beneficiary access to home service and then we'll put in supporting text that says we would like the surveys to reach to other sites or other sources of information along those lines.

DR. NELSON: Yes, and include within that the kinds of services because anecdotally some organizations are substantially changing the menu of services they provide. They still have the number of visits but they aren't doing ventilation services, they aren't doing diabetes teaching. They're doing that in order to prevent losses and that needs to be examined, as well.

MR. HACKBARTH: Since we're on recommendation three, why don't we go ahead and vote on that? Do people feel comfortable voting with the description that Mark just gave?

So all in favor of recommendation three as modified by Mark?

Opposed?

Abstain?

Let's go back to recommendation number one. All those in favor of recommendation number one?

Opposed?

Abstain?

Okay, recommendation number two. This would be modified to strike the e.g., so it's an explicit recommendation to do 5 percent.

DR. NEWHOUSE: Probably the whole thing needs to be somewhat reworded, not just strike the e.g.

MR. HACKBARTH: Okay, but substantively, the change is dropping for example and making an explicit recommendation of a 5 percent rural add-on.

DR. MILLER: We can just say at a lower rate of 5 percent.

MR. HACKBARTH: All in favor of number two as modified?

Opposed?

Abstain?

Okay, thank you, Sharon.